

## **Assessing payment adequacy and updating payments for skilled nursing facility services**

**ISSUE:** Are Medicare payments for skilled nursing facility (SNF) services at least adequate to cover the costs of caring for Medicare SNF patients? What update would be needed to account for anticipated changes in efficient SNFs' costs in the coming year?

**KEY POINTS:** At this meeting, staff will review information regarding fiscal year 2003 estimated Medicare margins for SNFs, trends in current costs, and market factors used to assess the relationship of payments to costs. In addition, we will present preliminary information on trends in the quality of care in SNFs. We will also present draft SNF recommendations, similar to those presented at the December Commission meeting, for the Commission's consideration.

Staff conclude from a review of the available evidence:

- Aggregate Medicare payments for skilled nursing facilities are more than adequate to cover the costs of caring for Medicare SNF patients for fiscal year 2003, although the SNF classification system appears not to distribute Medicare payments appropriately to account for the expected resource needs of different types of Medicare beneficiaries;
- SNFs have decreased the costs of caring for Medicare patients since implementation of the SNF prospective payment system (PPS), although we can find no evidence of decreases in the quality of care SNFs provide to these patients;
- The total number of SNFs participating in Medicare has remained relatively stable since implementation of the SNF PPS, with the number of freestanding SNFs increasing slightly and the number of hospital-based SNFs continuing to decline;
- The overall volume of SNF services provided to Medicare beneficiaries increased from 1999 to 2000, the most recent year for which we have data, with increases in the average length of stay leading to increases in the total number of Medicare covered days in SNFs;
- Medicare patients requiring rehabilitation therapy services generally experience no delays in accessing SNF services, while certain Medicare beneficiaries with expensive, non-rehabilitation therapy needs may remain in the acute-care hospital setting longer than before the SNF PPS. It is unclear whether additional time in the hospital is an inappropriate outcome for these patients; and
- Hospital-based SNFs' access to capital depends on the financial condition of the hospital as a whole (see discussion of hospitals' access to capital). Freestanding SNFs' (90 percent of all SNFs) access to capital may have been affected by recent bankruptcies, uncertainties about government revenues, and the costs of liability lawsuits and insurance. However, the demand for capital to finance new constructions appears to be low in the near term because of large capital investments in this sector prior to the SNF PPS.

**ACTION:** Commissioners should discuss the tone, findings, and draft recommendations for the chapter on SNFs (Chapter 2C) of the March 2003 report. The Commission's recommendations about updating payments for skilled nursing facility services will be included in the March 2003 report.

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## **Assessing payment adequacy and updating payments for home health services**

**ISSUE:** Are Medicare's current payments for home health episodes adequate compared with the costs agencies incur in furnishing care? How are costs per home health episode likely to change over the coming year?

**KEY POINTS:** Staff concludes that our estimates of home health agencies' current Medicare financial margins, along with other market factors, indicate that current Medicare payments per episode are more than adequate when compared to providers' costs. Although home health agencies are likely to face increasing input prices during the coming year, we expect a decline in the costs per episode because continuing declines in the number of visits per episode will more than offset the effects of rising prices.

Other market factors also indicate that payments are at least adequate when compared to costs. In the first full year following the implementation of episode-based prospective payment rates, access to care was generally good, and quality of care indicators remained about the same. The rate of decline in the number of users slowed. The number of agencies has remained stable for the third year in a row, with little exit and entry.

Declines in lengths of stay (duration of care) and visits per episode both indicate that the home health product is changing. As would be expected under the incentives of the prospective payment system, beneficiaries are receiving fewer visits and less aide service in a shorter period of time than they did two years ago under the interim payment system. In addition, an increasing proportion of all visits involve therapy services.

**ACTION:** This presentation is the last in a series of three presentations on payment adequacy and update analysis for home health services. At this meeting, staff will present an estimate of the current Medicare margins for home health agencies, discuss a new indicator of quality, and propose recommendations regarding an update for the coming year. The analysis and recommendations that you approve at this meeting will form a chapter in our March 2002 report.

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